Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	St. Michael's House
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	18 October 2024
Centre ID:	OSV-0001827
Fieldwork ID:	MON-0045017

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St. Michael's House is a large detached one-storey building located just outside a small village but within close driving distance to a nearby town. The centre mainly provides full-time residential support but also some shared care for a maximum of five residents of both genders over the age of 18 with intellectual disabilities. Five single resident bedrooms are present in the centre along with a kitchen-dining room, a sitting room, a visitors' room, a utility room, bathrooms and staff rooms. Residents are supported by the person in charge, social care staff and care staff

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 18 October 2024	08:30hrs to 16:35hrs	Conor Dennehy	Lead
Friday 18 October 2024	08:30hrs to 16:35hrs	Robert Hennessy	Support

What residents told us and what inspectors observed

Four residents were living in this centre, all of whom were met by inspectors. Three of these residents communicated verbally and some positive feedback was received. However, one resident indicated that they did not like living in the centre due to another resident.

On arrival at this centre two residents were present in the entrance hall area. One of these residents opened the front door to the inspectors who showed this resident their photo identification before entering. This resident did not generally communicate verbally with the inspectors but when prompted by the staff member present, they did give their name. The second resident present at this time greeted the inspectors and shook their hands. A third resident came out of their bedroom soon after and also greeted both inspectors with a handshake.

An inspector later spoke with this resident in their bedroom. The resident told the inspector that they used to live in another centre previously but did not like it there so moved to the current centre which they did like. They said they like this centre because "it's a quiet house" and that they got on with the other residents living in the centre. When asked by the inspector, the resident said that they felt safe in the centre and commented positively on staff working in the centre describing them as "very good, brilliant". This resident also said that they always knew the staff who were working in the centre in the centre.

Just inside the front door of the centre was a noticeboard which was to show photographs of the different staff members who were on duty day and night for each day of the week. While there was some staff photographs on this noticeboard for some days, there was one day with no photograph shown while no photographs were on display for some night shifts. Aside from this noticeboard, other signs or posters on display in the centre covered topics like rights, advocacy and complaints. It was noted though that the posters on display around complaints identified two different individuals as being the complaints officer. This was highlighted to the person in charge for the centre.

Shortly after the inspectors had arrived in the centre, they provided the staff member initially present with 'Nice to meet you' documents which introduced both inspectors individually and explained why they were in the residents' home. This staff member was later overheard explaining these 'Nice to meet you' documents to two of the residents. Not long after this staff member had done this, other staff arrived at the centre to commence their shifts. This included one staff member who was working their first day in the centre. This new staff was overheard introducing themselves to the residents.

The fourth resident who lived this centre introduced themselves to inspectors as the morning progressed. This resident was initially not impressed when they were told that one of the inspectors was from Kerry and the other was from Cork but they

later engaged jovially with both inspectors around GAA. One of the inspectors asked at this time if he could see the resident's bedroom. The resident agreed to this. As the resident was showing the inspector their bedroom, they indicated that did not like living in the centre as they did not like when another named resident "pucked" them. Records reviewed indicated that there had been some incidents between these residents which will be discussed later in this report.

While showing the inspector their bedroom, this resident showed off some army medals that they had collected and it was seen the resident's bedroom was nicely presented and personalised. Two other resident bedrooms were seen also which were personalised. For example, one resident's bedroom had an extensive sound system present. All bedrooms seen had appropriate storage facilities provided for residents to store their personal belongings. Communal facilities, such as a visitors' room, sitting room and kitchen-dining room, were provided and overall the premises provided in the centre was clean and reasonably presented on the day of inspection.

The centre had access to a vehicle which supported activities. During the inspection some residents talked about some of the things they did away from the centre such as having lunch out or attending social farming. Residents left the centre during the inspection using the centre's vehicle. First, two residents used this to go to another centre operated by the provider for horse riding and a walk. When these two residents returned to the centre in the early afternoon, after spending some time in the centre, all four residents left the centre with staff to go into a nearby town to do some errands and to get something to eat. Towards the end of the inspection, just three of the residents returned to the centre with inspectors informed that the fourth resident was staying overnight with a relative.

During the course of the inspection, the atmosphere in the centre in the centre was generally relaxed with residents appearing to be content or happy. For example, one resident was seen regularly smiling while some residents were seen having breakfast together while having a friendly chat. One resident also made tea for one of the inspectors. Staff were observed and overheard to be pleasant and respectful in their interactions with residents. It was noted though that one resident could be heard talking more than others. Other residents present did not appear to notice or react to this. At two points though an inspector did overhear disagreements between this resident and another resident. For one of these, the person in charge interjected while for the second staff present interjected.

In summary, one resident indicated that they did not like living in the centre but a relaxed atmosphere was generally encountered in the centre on the day of inspection. All residents left the centre at least once during the inspection using the vehicle provided. The centre where residents lived was seen to be clean and reasonably presented.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Some regulatory actions were identified during this inspection in areas such as staff supervision and provider six monthly unannounced visits. Such actions were contributed by the person in charge arrangements for the centre but some positive aspects of safeguarding practices were identified during the inspection.

This designated centre had been last inspected by the Chief Inspector of Social Services in August 2023 where an overall good level of compliance with regulations was found. Following that inspection the centre had its registration renewed until February 2027 with no restrictive conditions. In the months leading up to the current inspection, the Chief Inspector had commenced a programme of inspections focused on the area of safeguarding. This is a key area in supporting residents in designated centre as having appropriate safeguarding measures and processes in place helps to ensure that residents are safe and live a life free from harm. Given the length of the time since previous inspection of this centre and as some notifications of a safeguarding nature had been received from the centre since then, a decision was made to conduct the current inspection to focus on safeguarding in the centre.

During this inspection some positive aspects of safeguarding practices were found in the centre. For example, measures were in operation to ensure that residents were not subject to financial abuse while the provider also had a relevant policy in place. Staff knowledge around safeguarding generally was reasonable, although staff did not demonstrate an awareness of relevant standards related to adult safeguarding. Gaps in formal staff supervision and staff team meetings were also identified. Such matters were contributed to by the person in charge arrangements for the centre with the appointed person in charge being an area manager for other designated centres operated by the provider. This remit impacted their ability to oversee all relevant matters which were the responsibility of the person in charge under the regulations. Some regulatory actions were also identified relating to aspects of auditing and provider six monthly unannounced visits.

Regulation 15: Staffing

Staffing in a designated centre must be in accordance with the needs of the residents and a centre's statement of purpose. The statement of purpose seen during this inspection had been reviewed in June 2024 and contained details of the staffing to be provided in the centre. An inspector did note a minor inaccuracy related to some staff hours of work in this statement of purpose but from discussions with staff and rotas reviewed that staffing provided in the centre was in keeping with the needs of residents. While there was some staff vacancies in the centre at the time of this inspection, these were being filled by regular relief and

agency staff.

Whether employed directly by the provider or sourced from an agency external to the provider, the provider is required to ensure that certain documents such as written references, photo identification and evidence of Garda Síochána (police) vetting is maintained for all staff. An inspector reviewed four staff files and found that the majority of the required documentation was in place but recent photo identification was missing for one agency staff member. It was also noted that the most recent Garda vetting in place for one staff member was from 2011 with the provider's vetting policy not providing direction on how often staff were to be re-vetting. Inspectors were informed that this matter had been raised with the provider's human resources department and staff across the provider were being invited to redo their Garda vetting.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Under this regulation, the person in charge must ensure that copies of relevant standards, regulations and the Heath Act 2007 must be available to staff. Within the centre, it was seen that copies of these were in place but inspectors were informed by the person in charge that a copy of relevant adult safeguarding standards, which had been published in 2019, and other relevant safeguarding guidance were not present in the centre. The person in charge must also ensure that staff are informed of such standards but staff spoken with did not demonstrate an awareness of these adult safeguarding standards. It was acknowledged that staff knowledge around safeguarding generally was reasonable overall.

Aside from this, the person in charge must also ensure that staff are appropriately supervised. It was indicated during this inspection that staff were to be formally supervised every six to eight weeks. However, when an inspector reviewed supervision records it was evidenced that this was not happening. For example, one staff member had a record of only one formal supervision being completed in 2024. The provision of timely staff supervision had also been highlighted as a regulatory action during the August 2023 inspection and the provision of this was being impacted by the remit of the person in charge.

It was acknowledged though that where formal staff supervision had taken place in 2023 and 2024, matters related to safeguarding were indicated as being discussed. Safeguarding was also recorded as being discussed in the notes of staff team meetings seen from February 2024 and August 2024. These were the only notes of two staff team meetings from 2024 present but inspectors were informed that there had been another such meeting in September 2024. Inspectors were also informed that these staff team meetings were to take place on a monthly basis.

Records provided following this inspection indicated that staff had received relevant

training although there were some gaps. These included;

- Three staff who were overdue refresher training in de-escalation and intervention and one staff was not indicated as having completed this training.
- One staff who was overdue refresher training in safeguarding.
- Four staff who were overdue refresher training in Children First and two staff were not indicated as having completed this training.
- Three staff who were overdue refresher training in fire safety.

Judgment: Not compliant

Regulation 23: Governance and management

The person in charge plays a key role in the governance of a centre. The current person in charge had been appointed in June 2023 and did have the support of a team leader for this centre for a time. However, the team leader role had not been in place since May 2024. At the time of this inspection, the person in charge was only responsible for this designated centre as a person in charge but they also held an area manager remit with the provider. This meant that they were also involved in the management of other designated centres. This reduced their ability to focus fully on this designated centre and contributed to some of the regulatory actions found on this inspection. However, staff spoken with did highlight that the person in charge was in regular contact with this centre and there were records of the person in charge visiting the centre. The person in charge also demonstrated a good awareness of the residents living in this centre during discussions with inspectors.

On occasion, the person in charge would be available to provide out-of-hours support for the centre as part of an on-call system which involved other members of the provider's management team on a rostered basis. Staff spoken were aware of this on-call system and indicated that when they had needed to use this, the assigned on-call person had always responded. Beyond the on-call system, the provider was also seeking to maintain oversight of the centre by conducting unannounced visits to the centre. Such visits are required by the regulations to be conducted every six months. Two unannounced visits had been conducted since the August 2023 inspection, one in November 2023 and the other in June 2023. While reports of these visits indicated that relevant matters relating to residents' care and support, such as safeguarding, were considered, there had been a gap of over seven months between these two unannounced visits.

In addition, it was noted that both of these unannounced visits had been conducted by the person in charge. Given that the person in charge role holds specific regulatory responsibilities for matters related to residents' care and support, the current person in charge conducting such visits for this centre required review from an overall oversight perspective. Actions plans for both the November 2023 and June 2024 unannounced visits were in place. These action plans set out time frames

and responsibilities for addressing any areas identified as needing improvement. It was noted though that neither action plan had been updated to reflect progress made with these actions with some actions repeating from November 2023 unannounced visit to the June 2024 one.

An action plan was also in place for the most recent annual review completed for the centre but it was seen that this not been updated either to reflect if actions had been completed. Such an annual review is also required by the regulations and when reading the report of this annual review, it was seen that it assessed the quality and safety of care and support provided against relevant national standards. Consultation with residents and their representatives was included within the report of the annual review with feedback from both indicted as being generally positive. The report of an annual review must to be made available to residents. When queried how this was done, inspectors were informed that actions arising from the annual review were discussed with residents but that the report itself was not being provided to residents.

Beyond the requirements for annual reviews and provider unannounced visits, audits were being conducted at a local level in the centre. Such audits covered areas such as medicines, finances and safeguarding. Records provided indicated that, in recent months, two safeguarding audits had been conducted in the centre including one by the provider's designated officer (person who reviews safeguarding concerns). Conducting such audits is important to review the care and support provided for residents as it promotes systematic monitoring of a centre. An audit schedule was in place to promote this also but it was noted that this schedule did not always make clear when certain audits were next to be done. For example, it was indicated that one pharmacy audit was to be done and while, one had been done in January 2023. It was unclear when the next one was to take place. Issues around the audit schedule for the centre had been raised in the August 2023 inspection also.

Judgment: Substantially compliant

Quality and safety

This inspection found evidence of good safeguarding practices in some areas. However, there had been some safeguarding incidents occurring involving negative interactions between residents.

As highlighted earlier in this report, one resident indicated that they did not like living in this centre which related to another resident. Before and since the August 2023 inspection of this centre, there had been incidents occurring between these residents. Such incidents were related to the particular needs of one of the residents and staff had a good knowledge of how to support the resident in this area. Despite this, such incidents did have the potential to impact residents' rights in their home and it was highlighted that one resident had requested to move elsewhere in

response to such incidents. A potential placement in another of the provider's centres had been identified for this resident and a potential transition there was being considered further at the time of this inspection. Aside from this, evidence was found during this inspection of positive aspects of safeguarding practices in the centre. This included, the presence of safeguarding plans, staff awareness of different types of abuse and the availability of a designated officer.

Regulation 10: Communication

Residents had access in this centre to appropriate media, such as television and radio. Most of the residents living this centre communicated verbally but one resident generally did not. While it was indicated that this resident did not use any assistive technology, it was highlighted that they could make their choices known and also used particular hand gestures as a form of communication. Staff members spoken with during this inspection were generally aware of how this resident communicated. A resident's personal plan contained guidance on the resident's communication needs and supports. This personal plan made clear reference to the resident have a communication folder which contained further guidance in this area. When an inspector requested to view this communication folder, it could not be located on the day of the inspection. One week following this inspection communication was received from the person in charge confirming that all residents in the centre had communication profiles in place.

Judgment: Substantially compliant

Regulation 17: Premises

The premises provided for this centre was seen to be reasonably presented, clean and homely on the day inspection. Sufficient communal space, bathroom and storage were available for the four residents who were living in this centre at the time of this inspection although a vacant bedroom was also being used for storage purposes. Each of the four residents living in the centre had their own individual bedroom, all of which were seen by the inspectors. These bedrooms were well-decorated and personalised to the residents with storage available for residents to keep their personal items.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Under this regulation, residents must have individualised personal plans provided which are intended to identify the health, personal and social needs of residents while also providing guidance on meeting these needs. During the inspection, the personal plans of all four residents were reviewed by inspectors. These plans were generally found to contain recently reviewed guidance on supporting residents while there was also documentary evidence of annual multidisciplinary reviews taking place. A process of person-centred planning was used to identify goals for residents to achieve such as overnight stays away or going to see a Christmas panto. Documents reviews indicated that time frames and responsibilities were assigned for supporting residents with such goals.

When reviewing one resident's personal plan it was noted that their current goals had been identified in September 2024 which were being progressed. However, based on the documents available in the resident's personal plan, these were the first goals worked on for the resident since August 2023. When queried with the person in charge this gap was put down to the resident not having a key-worker (a staff specifically assigned to support a resident) for a period. It was also highlighted that the particular needs of this resident did present challenges in identifying goals for them. An inspector also queried with the person in charge if residents had accessible versions of their personal plans as required under this regulation. While it was indicated that there was some easy-to-read documents for residents in the centre, the inspector was informed that residents did not have accessible versions of their personal plans in place.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Specific support plans was available for staff within residents' overall personal plans which provided guidance and information on how to encourage residents to engage in positive behaviour. Staff spoken with demonstrated a good awareness of residents' needs in this area and outlined how they would support residents depending on the presentation of residents. Given the particular needs of one resident, their support plan made reference to use particular de-escalation and intervention techniques in response to particular situations. Training records provided following this inspection indicated that most staff had completed training in de-escalation and intervention albeit there were some gaps as highlighted under Regulation 16 Training and staff development.

The provider had processes in place to review any restrictive practices in the centre. This included input and review by a multidisciplinary team. Documentation reviewed indicated that there was limited restrictive practices in use in the centre and that some previous restrictions in use had been removed. For example, a drawer that was previously locked in the kitchen was now accessible to residents. While there were some key codes in use in places, inspectors were informed that residents knew these codes and were able to move around the centre and its grounds. Throughout

the inspection, residents were seen to freely move around the centre with no environmental restrictions observed.

Judgment: Compliant

Regulation 8: Protection

During this inspection the following positive aspects were identified regarding safeguarding practices in the centre;

- The provider had overall safeguarding policy in place as well as a safeguarding committee whose membership included senior management of the provider, a social worker and the provider's designated officer.
- This designated officer was available to the centre and contact information about this person was on display in the centre.
- Residents were made aware of who the designated officer during residents meetings where safeguarding was indicated as being regularly discussed. One resident had, on occasion, directly contacted the designated officer themselves.
- Staff spoken with during this inspection were aware of who the designated officer was and demonstrated a good awareness of how report safeguarding concerns
- Such staff also had a good understanding of the different types of abuse that can occur and the signs that abuse could be occurring.
- Aside from gaps noted under Regulation 16 Training and staff development, training records provided following this inspection indicated that most staff had completed training in safeguarding and Children First.
- Residents had intimate personal care plans provided which provided guidance for staff in supporting the needs of residents in such areas.
- Processes were in place to safeguarding residents' finances. For example, residents' finances were securely stored and residents were supported with their finances in the centre with receipts kept of transactions made based on a sample of records reviewed for two residents. Such transactions were also double signed.
- Documentary evidence was provided during the inspection that some incidents or allegations of an alleged safeguarding nature had been referred to the provider's designated officer with relevant referrals made to the Health Service Executive Safeguarding and Protection Team where necessary.
- Some incidents occurring in the centre were contributed to by the particular needs of one resident. As discussed under Regulation 7 Positive Behavioural support, staff were aware of this resident's needs and how to respond.
- Where any safeguarding concerns were identified, safeguarding plans were developed which outlined measures to safeguard residents. There were indications that such measures were being implemented in practice. For example, one staff member outlined that specific seating arrangements were to be followed when using the centre's vehicle due to a past incident with

these seating arrangements observed to be followed during this inspection.

Despite these positive elements, some areas for improvements were identified. These included;

- While staff spoken with made explicit reference to active safeguarding plans concerning some residents, two staff did not demonstrate an awareness of active safeguarding plans relating to one resident.
- Between the August 2023 inspection and the current inspection, incidents of a safeguarding nature were received involving residents impacting one another. The majority of these incidents tended to involve two residents and one of these residents commented that they did not like living in the centre due to the other resident. Some of these incidents were also impacting residents' rights in their home as will be discussed under Regulation 9 Residents' rights.
- When reviewing a safeguarding folder in the centre, an inspector came across a safeguarding action plan. It was unclear if the information in this safeguarding action plan was up-to-date or not. For example, this made reference to maintaining an access log for one resident and while there was an access log in place, from discussions with the person in charge it was unclear if it was being used correctly.
- While documentary evidence was provided that some incidents or allegations of an alleged safeguarding nature had been referred to Health Service Executive Safeguarding and Protection Team, similar documentation was not available for six specific incidents or allegations on the day of inspection. During the feedback meeting for the inspection the provider was afforded additional time to submit the relevant documentation by 21 October 2024. While relevant documentation was submitted confirming that five of the incidents or allegations had been appropriately referred, such documentation was only received on 29 October 2024. No documentation relating to the sixth incident or allegation was provided following the inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were treated in a respectful manner on the day of the inspection. Resident meetings were taking place which were used to give residents information in areas such as safeguarding, complaints and meal plans although some of the content of these meetings were repetitive. In the months leading up to the current inspection, these meetings had been occurring consistently on a weekly basis although some gaps in these meetings were noted during March and April 2024. Aside from such meetings, when reviewing the person plan for one resident it was seen that the resident had a consent sheet that was dated April 2024. This was intended to be used to document if the resident had consented to certain matters such as attending a general practitioner, getting vaccines and having their pictures

used in the provider's media. This sheet was indicated as being signed on behalf of the resident's family by a staff member and it was unclear if the resident themselves had consented to all matters included, particularly having their pictures used in the provider's media. When queried it was indicated that this consent sheet should have been accompanied by an easy-to-read consent sheet for the resident but this could not be located for 2024.

While this did need review, instances were observed where residents' rights were respected or where they were consulted in matters that were relevant to them. For example, one resident was seen to have their own key to their bedroom which they used throughout the day, a second resident was also supported to spend time in the centre on their own while a third resident was seen to be encouraged to make their own tea. It was also indicated that in the days leading up this inspection, one resident had suffered a cut from a fall when in their bedroom which required medical attention. On account of this accident, a relevant risk assessment related to the resident's bedroom had to be updated and during the morning of the inspection the person in charge was overheard discussing this matter with the resident. Near the end of the inspection it was also seen that the resident was involved in discussions about this again with the person in charge and a member of the provider's senior management who had attended the centre for inspection feedback.

As mentioned earlier in this report. There had been some safeguarding incidents occurring in the centre involving residents impacting on one another. Some of these had involved residents being asked to remain in their bedrooms due to the presentation of one resident. It was indicated though that these residents would agree to such requests. In one incident though it was referenced that a resident moved from the kitchen-dining room into the sitting room to have a meal due to their peer's presentation. Some incidents had also occurred where the same resident had entered the bedroom of a different resident who did not like this. Such instances impacted residents' rights in their home. On account of such matters, one resident had indicated that they did not like living in the current centre and had expressed a wish to live elsewhere. At the time of this inspection, the provider had identified a potential placement in another of their designated centres and the resident was keen on this. The process for the resident moving to this other centre was at the early stages and would be subject to further assessment and consultation with relevant stakeholders.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Michael's House OSV-0001827

Inspection ID: MON-0045017

Date of inspection: 18/10/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To come back into compliance with Regulation 15, the Person in Charge has identified the following items: The staff file for an identified agency staff has been updated to include a more recent photo identification. Ongoing active recruitment process in place for permanent staff. The Registered Provider ensures that all staff are Garda vetted as per of its on-boarding process. The Registered Provider has a plan in place to have all their staff re-vetted with the next 18 months and to maintain this on a 3-5 year basis.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge can confirm that relevant external adult safeguarding standards are now in place within the centre. These standards will be included on the agenda for future staff meetings to build knowledge and insight. A copy of these standards will also be available in the designated centre.	

The Registered Provider would like to confirm that while gaps were identified in some supervision records, supervision was completed for the core group of staff.
The Person in Charge wishes to confirm that that the one staff member who only received one formal supervision has now received a second supervision and will be included in the staff supervision schedule.
To address the identified gaps re. supervision, the Person in Charge will conduct supervision quarterly as per the Registered Provider own policy. The Person in Charge will ensure implementation of a structured staff supervision system. The Person in Charge will conduct direct supervision for of the staff within the designated centre prior to delegating supervision duties to Social Care Workers for Healthcare Assistants with the Person in Charge maintaining oversight over same.
The Person in Charge wishes to confirm that the minutes of the staff meeting of the 30th of September have now been typed and evidenced in the staff meeting folder with a copy of same submitted to the inspector post inspection.
The Person in Charge would like to confirm the following training matrix has been reviewed and update.

CPI training
• Staff 1 -completed CPI Refresher – 15/08/24
• Staff 2 –completed – 06/06/2024
• Staff 3 – completed CPI 1 on 31/10/2024

Fire Safety:
• Staff one – Fire Training – Expired – 27/09/24 – scheduled and booked on Wednesday, 4 December 2024
• Staff 2 Fire Training – Valid – 16/10/2026
• Staff 3 – Fire Training – Expired – 04/11/2024 – Scheduled 4/12/2024
•
Children First:

• 4 staff will have training completed by 25th of November.

Safeguarding :

• The Person in Charge wishes to confirm that online safeguarding for one staff was completed on the 14th of February 2024,with face to face training booked for the 9th of December 2024.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider wishes to confirm that the recruitment process of a Person in

Charge remains active. The Registered Provider has supported the current Person In Charge with the appointment of a Team Lead familiar to residents and the centre to ensure governance and oversight.

The Person in Charge would like to acknowledge a gap of seven months between two unannounced visits to the designated Centre. The Person in Charge wishes to assure the Chief Inspector that they will ensure going forward that these unannounced inspections will be completed within the six-month regulation period.
The Registered Provider will review its internal process to ensure that internal 6 monthly and annual reviews will be completed by a PPIM who does not hold responsibility for the designated centre.

The Registered Provider confirms that it uses action trackers to monitor the progress and status of identified actions arising from both internal and external inspections. The Registered Provider accepts the shortcomings identified regarding some open actions, the Registered Provider will implement a Person in Charge feedback report which will incorporate a number of key process indicators (KPIs) which will incorporate the action status arising from both internal and external inspections.
Going forward the Person in Charge will ensure that the Centres annual review will be communicated to the Residents through the forum of a residents meeting. The Person in Charge can confirm that a copy of this inspection has been made available to all residents in the Designated Centre.
The Registered Provider wishes to assurance the Chief Inspector that the designated centres audit schedule will be amended and standardised to reflect a calendar year.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
The Person in Charge would like to confirm that a communication profile designed by the Speech and Language department was sent to the Chief Inspector on the 25th of October 2024.
The Person in charge wishes to confirm that this document is now available within the Designated Centre to support the resident It was unavailable on the day of inspection as the Speech and Language Therapist was making amendments and preparing the document.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Person in Charge wishes to confirm that all residents are now assigned a key worker as a result of a new SCW commencing employment.

The Registered Provider wishes to acknowledge that inappropriate entries had been made in relation to visits/visitors being recorded in a resident's access log. This has now been addressed, and going forward, these visits/visitors will be recorded in the resident's daily notes. This access log will remain place for its original purpose. Clear guidance is now in place to inform staff in relation to logging access visits.

The Registered Provider will ensure that where required easy read documentation around the care plan will be implemented for a resident with additional communication requirements

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Person in Charge wishes to confirm to the Chief Inspector that an identified staff member has been made aware of all active safeguarding plans within the designated centre and is now familiar with same. Furthermore, a staff meeting took place on the 18th of November 2024 – which spoke extensively about open safeguarding's within the centre, along with the positive behavior support plans in place to support residents. The aims of these discussions were to increase the safeguarding knowledge and awareness for all staff. Additionally Safeguarding is a running agenda items on all staff meeting.

During the inspection on 18 October 2024 specific records relating to six safeguarding matters were not available for review by the inspector.
In the feedback meeting for the inspection the lead inspector explicitly requested that these be provided by 21 October 2024.
Five of the six records requested were provided but only on 29 October 2024
The Registered Provider acknowledges and apologises to the lead inspector and Chief Inspector that there was a delay in providing the requested records with the sixth record not provided until 21 November 2024.

To address the safeguarding concerns in the designated centre, the Provider has a plan which recognizes the will and preference of a resident's desire to be relocated. To that end the Registered Provider is currently undertaking a compatibility assessment to identify a potential compatibility with the residents of another designated centre. This compatibility assessment is in progress and has a completion date of the 6th of December 2024.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
While the Registered Provider acknowledges that gaps were identified in relation to resident's meetings in March and April of 2024, the Registered Provider can now confirm that the weekly resident's meetings are occurring as observed on the day of the inspection.
The Person in Charge wishes to assure the Chief Inspector that the discussed easy read consent form has been reviewed with active involvement and the approval of one identified resident. An easy read care plan template has been created for one resident who is nonverbal. This was completed by 15th of November 2024.
As stated in response to Regulation 8, the Provider wishes to assure the Chief Inspector that a number of compatibility assessments are in progress in recognition of the expressed preference of one resident to seek an alternative residential relocation within the Registered Provider's services. These compatibility assessments also involve other residents who have expressed a wish to relocate or who's needs have changed.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	25/10/2024
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	01/06/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional	Not Compliant	Orange	09/12/2024

	development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2024
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations and standards made under it.	Substantially Compliant	Yellow	20/10/2024
Regulation 16(2)(b)	The person in charge shall ensure that copies of the following are made available to staff; standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	20/10/2024
Regulation 16(2)(c)	The person in charge shall ensure that copies of the following are made available to staff; relevant guidance issued from time to time by statutory and professional bodies.	Substantially Compliant	Yellow	20/10/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Substantially Compliant	Yellow	28/02/2025

	to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Substantially Compliant	Yellow	30/11/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/12/2024
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six	Substantially Compliant	Yellow	30/12/2024

	months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/11/2024
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/11/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	06/12/2024
Regulation 09(2)(a)	The registered provider shall ensure that each	Substantially Compliant	Yellow	15/11/2024

	resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	15/11/2024